

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An unannounced annual survey was conducted at this facility from January 19, 2017 through January 26, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 142 (one hundred forty two). The survey sample totaled 38 (thirty eight).</p> <p>Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FMD - Facility Maintenance Director; NP-Nurse Practitioner; ADL - Activities of Daily Living, such as bathing and dressing; Anti-rollbacks - device preventing wheelchair from rolling backwards; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15; 13-15: Cognitively intact; 08-12: Moderately impaired; 00-07: Severe impairment; cc (Cubic Centimeter) - unit of volume; CDC - Centers for Disease Control; Controlled substance - a drug that is regulated by the government; Cognitive - mental process or thinking;</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/17/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page 1 d/c-discontinue; Dycem - non skid material used to prevent slipping; EMR - electronic medical record; mcg (Microgram) - metric unit of weight, 1,000 mcg equals 1 mg; MDS - Minimum Data Set (standardized assessment forms) used in nursing homes; mEq (Milliequivalent) - metric unit of weight, 10 mEq potassium equals 390 mg; mg (Milligram) - metric unit of weight, 1 mg equals 0.0035 ounce; mL (Milliliter) - metric unit of liquid volume, 5 ml equals 1 teaspoon; Narcotic- controlled substance affecting the mood or behavior; PASRR II (Preadmission Screening and Resident Review) - in depth screening to determine recommended services needed; PRN - as needed; Psychiatric - treatment of mental disorders; Psychiatrist-physician who specializes in the diagnosis, prevention and treatment of mental disorders; Psychotherapy - talk therapy or counseling; pneumonia-infection that inflames the airsacs in one or both lungs; w/c - wheelchair; x - times.	F 000			
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private	F 164			3/31/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 164	<p>Continued From page 2 room for each resident.</p> <p>(h)(3)The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>§483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on interviews and observation it was determined that the facility failed to provide</p>	F 164	<p>A.) Facility cannot provide retroactive compliance to R5 or RA.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 164	<p>Continued From page 3</p> <p>privacy for two (R5 and RA [resident who wished to remain anonymous] out of 38 sampled residents. Findings include:</p> <p>1. During stage 1 interview with RA on 1/20/17 at 11:15 AM, when asked "Does staff provide you privacy when they work with you, changing your clothes, providing treatment?" the resident said "No. When I go to the bathroom I like privacy." RA said that after midnight a couple weeks ago, E16 (CNA) entered the bathroom at least three times when the resident was on the toilet to get gloves and other items to provide care for RA's roommate. After RA said she told E16 s/he likes privacy when on the toilet E16 slammed the bathroom door when she left the bathroom. The resident said after leaving the bathroom E16 said "Ever since you got here, you act like you own the place."</p> <p>As the stage 1 interview continued on 1/20/17 around 11:25 AM, RA said "the other night when watching TV I saw someone go into bathroom around 7:30 PM - 8:00 PM and I yelled who are you what are you doing in my bathroom?" RA said that E17 (CNA) claimed he knocked and was there to do an audit. When asked by RA "An audit for what?" E17 responded "On your books." RA described how E17 opened all the bureau drawers for both residents in the room. "He didn't touch anything, just looked then opened the blinds but didn't put them back right." RA said s/he was not sure why the man did what he did that night.</p> <p>During an interview with E3 (ADON) on 1/20/17 at 3:40 PM E3 stated that a CNA was on light duty and had been checking rooms and making sure personal items had been put away. When asked</p>	F 164	<p>B.) All Residents could potentially be affected.</p> <p>C.) All staff will be re-educated by Staff Developer on current privacy practices with a video extended training focusing on scenarios and role-playing. This extended education will be applied to future new hire orientations.</p> <p>D.) All non-clinical Directors will audit up to five (5) privacy interactions per week for a collective of twenty (20) observations a week. Compliance of audit will be reviewed by Nursing Home Administrator (NHA). Facility will audit weekly for four (4) weeks until 100% compliance is reached for four (4) consecutive weeks. Then, monitor / audit monthly until consistently reaching 100% success for three (3) monthly evaluations. If 100% compliance is reached after the end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained. Evaluation success will be reviewed at Quarterly Quality Assurance meeting.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 4 if this person would have opened dresser drawers and raised blinds, she said "Yes that could be the same person." Surveyor explained resident concern of seeing person enter bathroom without asking permission to enter, an introduction or an explanation until addressed by the resident. During an Interview with RA on 1/26/17 at 9:05 AM the resident informed the surveyor "just had it again" and described being on the toilet when "the girl came in to empty the basin of water used for [roommate's first name]. When she saw me she said I thought you were in bed." When the surveyor asked if staff knocked on the door, RA stated "If they knock on the door, they open it instantly."	F 164		
F 246 SS=D	2. Observation on 1/26/17 at 11:52 AM - E21 (CNA) entered R5's room and bathroom without knocking. R5 was in the wheelchair at the sink when the CNA entered the bathroom. R5 confirmed at 11:57 AM that E21 entered the bathroom without knocking. These findings were reviewed with E1(NHA) and E2 (DON) on 1/26/17 at 3:20 PM. 483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to accommodate	F 246	A.) Facility immediately corrected R23 and R245's call bell lengths.	3/31/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 246	<p>Continued From page 5</p> <p>the individual needs of 2 (R23 and R245) out of 40 sampled residents by not ensuring that they could turn on the light in their room. Findings include:</p> <p>Observations made during Stage 1 (1/19/17 to 1/20/17 between 8:00 AM and 4:00 PM and on 1/23/17 between 8:00 AM and 12:00 PM) revealed that the lights above the beds of R23 and R245 had cords too short for the residents to reach.</p> <p>During a Stage 1 (1/19/17 to 1/20/17 between 8:00 AM and 4:00 PM and on 1/23/17 between 8:00 AM and 12:00 PM) interview R245 stated that he could not reach the cord and this was the only reason he could not turn the light on or off.</p> <p>Observations made at 11:17 AM on 1/25/17 revealed that the the lights over the beds of R23 and R245 had cords that were too short for the residents to reach from a sitting position.</p> <p>During an interview on 1/25/17 at 2:26 PM R23 said she could not reach her light cord and would like a longer cord. She explained that if she could reach the cord, she'd be able to turn the light on herself.</p> <p>During an interview at 11:00 AM on 1/26/17 E1 (NHA) made an observation of R23's light with the surveyor. E1 explained that the cord was short because the extension (meant to break-away to prevent accidents) had come off of the pull cord. The extension was found in R23's room, and E1 quickly attached it to pull the cord on the light. E1 explained that the nursing supervisors keep extra cords on the units to replace if necessary.</p>	F 246	<p>B.) All Residents could be affected. A whole house audit will be conducted to verify that all Light Control cords are the maximum length, with corrections made upon immediately upon discovery.</p> <p>C.) All replacement Light Control cords will be pre-cut to maximum manufacture's specifications. Length inspection will be added to the monthly preventative maintenance schedule on Light Controls.</p> <p>D.) Inspections and reports will bereviewed for accuracy and completeness, monthly, as part of the ongoing preventative maintenance reporting. Administrator and Maintenance Director will review monthly and report compliance to monthly and quarterly to the Quality Measures Committee and Quarterly Quality Assurance Committee, respectively.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 246	Continued From page 6	F 246			
F 253 SS=E	<p>Findings were reviewed with E1 and E2 (DON) on 1/26/17 at 3:20 PM.</p> <p>483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and interviews it was determined that the facility failed to maintain a sanitary, orderly, and comfortable interior in 9 (119, 124, 127, 131, 203, 305, 307, 354, and 366) out of 33 rooms reviewed and at one exit. Findings include:</p> <p>Observations made during Stage 1 (1/19/17 to 1/20/17 between 8:00 AM and 4:00 PM and on 1/23/17 between 8:00 AM and 12:00 PM) and during an environmental tour at 11:00 - 11:30 AM on 1/25/17 found:</p> <ul style="list-style-type: none"> -3 (124, 203, and 307) rooms with wall damage -4 (119, 127, 354, and 366) rooms with towel bars in disrepair -1 (131) room with a soiled privacy curtain -1 (305) room with a closet door in disrepair -1 (124) room with an electrical outlet missing a cover -1 exit door (near rooms 314 and 315) with missing weather stripping leaving a large gap at the bottom of the door <p>Findings were reviewed with E5 (FMD) at 8:57 AM on 1/26/17.</p>	F 253	<p>A.) Seventeen (17) Residents were potentially impacted, out of a possible sixty-six (66) reviewed. 1.) Rooms 124, 203, and 307 slight wall damages were immediately patched and repaired. 2.) Rooms 119, 127, 354, and 366 had towel bars replaced immediately. 3.) Room 131 Privacy Curtain was immediately replaced. 4.) Room 305 had their closet door immediately replaced. 5.) Room 124's outlet cover was discovered on electric device, replaced and secured immediately. 6.) Exit Door weather stripping was fixed immediately.</p> <p>B.) All Residents could potentially be affected.</p> <p>C.) Wall inspections, outlet cover inspections, towel bar inspections, closet door inspections, and secondary outlet cover inspections will be added to preventative maintenance list. Environmental Services vendor will add privacy curtain inspections to their preventative maintenance list.</p>	3/31/17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From page 7 Findings were reviewed with E1 (NHA) and E2 (DON) at 3:20 PM on 1/26/17.	F 253	D.) Inspections and reports will be reviewed for accuracy and completeness monthly as part of the ongoing TELS platform reporting. Privacy Curtains, though maintained by a vendor, will be added to the monthly TELS platform for inspection and compliance. Administrator and Maintenance Director will review monthly and report compliance to monthly and quarterly to the Quality Measures Committee and Quarterly Quality Assurance Committee, respectively.		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions.	F 272			3/31/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 272	<p>Continued From page 8</p> <p>(xiii) Activity pursuit.</p> <p>(xiv) Medications.</p> <p>(xv) Special treatments and procedures.</p> <p>(xvi) Discharge planning.</p> <p>(xvii) Documentation of summary information regarding the additional assessment performed on the _____ care areas triggered by the completion of the Minimum Data Set (MDS).</p> <p>(xviii) Documentation of participation in assessment. The assessment process must include direct _____ observation and communication with the resident, as well as communication with licensed and _____ non-licensed direct care staff members on all shifts.</p> <p>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record reviews and interviews, it was determined that the facility failed to conduct an accurate and complete comprehensive assessment in the area of dental for one (R73) out of 38 Stage 2 sampled residents. Findings include:</p> <p>Review of R73's clinical record revealed;</p> <p>Review of R73's annual MDS, dated 1/13/16, coded the resident as having "obvious or likely cavity or broken natural teeth."</p> <p>Review of R73's annual MDS, dated 12/15/16, coded the resident as having "none of the above</p>	F 272	<p>A.) Resident 73 was potentially impacted. All of R73's assessments and care plans were audited for clarification and re-assessment and staff interview conducted. Care plan clarified to current assessment.</p> <p>B.) All Residents that express dental pain and / or discomfort could be affected. Director of Nursing, Assistant Director of Nursing and Unit Managers will audit all progress notes for the past thirty (30) days to identify and complaints of dental pain and / or discomfort.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	Continued From page 9 were present", and that he is cognitively intact. R73 was observed by the surveyor on 1/20/17 at 11:00 AM to have missing and crooked teeth. During the stage 1 interview on 1/20/17 at 11:00 AM, R73 stated that he had missing upper teeth, difficulty chewing and two teeth partially coming in that are causing mouth discomfort. During an interview on 1/25/17 at 12:50 PM, E12 (RN, Unit Manager) stated she was not aware of him having current dental problems, and was able to find a note where she documented on 12/04/15 that he did not want to see a dentist at that time despite his "bad teeth". The facility failed to comprehensively and/or accurately assess R73's dental status on the 12/15/16 annual MDS assessment. These findings were reviewed with E1 (NHA) and E2 (DON) on 1/26/17 at 3:20 PM.	F 272	C.) Staff Developer will in-service on dental assessments, which will include assessments with Residents with aphasia. Oral assessments will be completed quarterly by nursing. Any Resident with complaints of dental pain and / or discomfort will be reviewed by the interdisciplinary team to develop a plan of care. D.) Minimum Data Set Coordinator (MDS Coordinator) will review five (5) Residents who have had dental assessments and there are notes regarding dental pain and / or discomfort , weekly for four (4) weeks until 100% compliance is reached for four (4) consecutive weeks. Then, monitor / audit monthly until consistently reaching 100% success for three (3) monthly evaluations. If 100% compliance is reached after the end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained. Evaluation success will be reviewed at Quarterly Quality Assurance meeting.		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.	F 279		3/31/17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	<p>Continued From page 10</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p>	F 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	<p>Continued From page 11</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop an accurate comprehensive care plan for one (R209) out of 38 sampled residents. Findings include:</p> <p>Review of R209's clinical record revealed:</p> <p>12/2/16 - admission to the facility with continuous tube feeding.</p> <p>12/9/16 - Admission MDS assessment documented the resident received nutrition by artificial route.</p> <p>12/12/16 - Care plan problem for self-care deficits included the intervention: Set up trays for meals, assist with feeding if needed, and monitor to ensure adequate intake of food and fluids. This intervention was not appropriate for this resident who was fed by a feeding tube.</p> <p>During an interview with E12 (RN, UM) on 1/24/17 at 3:35 PM confirmed the resident was receiving continuous tube feeding.</p> <p>This findings was reviewed with E1 (NHA) and E2</p>	F 279	<p>A.) Facility cannot provide retroactive compliance to Resident 209; however care plan was corrected immediately upon discovery</p> <p>B.) All Residents who are on "nil per os" (NPO), which means: nothing by mouth, could be affected. A whole house audit will be conducted for all NPO Residents to assure care plan interventions reflect current NPO status.</p> <p>C.) Education will be provided to Unit Managers, Dietitian, and Therapy Staff, that all NPO Residents must be reviewed for appropriate care plan interventions for NPO Residents. All NPO Residents will be reviewed by inter-disciplinary team, monthly, for appropriate care plan interventions are being used.</p> <p>D.) Once audit is complete, all newly identified NPO Residents will be reviewed within seven (7) days by Interdisciplinary Care Plan Team to ensure care plan</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page 12 (DON) on 1/26/17 at 3:20 PM.	F 279	interventions match current NPO status, weekly, for four (4) weeks until 100% compliance is reached for four (4) consecutive weeks. Then, monitor / audit monthly until consistently reaching 100% success for three (3) monthly evaluations. If 100% compliance is reached after the end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained. Evaluation success will be reviewed at Quarterly Quality Assurance meeting.		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 280			3/31/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	<p>Continued From page 13 of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	<p>Continued From page 14</p> <p>the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that for three (R65, R5 and R98) out of 38 sampled residents the facility failed to revise the care plan to reflect the residents' current care needs. Findings include</p> <p>1. Cross refer F323 example #1.</p> <p>Review of R65's clinical record revealed; R65 had a care plan initiated on 9/2/15 and last reviewed 1/5/17 that included an approach to use a Dycem in the wheelchair on top of and below the cushion.</p> <p>Review of the CNA book on the unit revealed a bright orange laminated sheet that documented (NAME OF RESIDENT) IS NOT TO BE LEFT UNATTENDED IN THE BATHROOM.</p> <p>During an interview with R65 on 1/24/17 at 10:47 AM about the Dycem cushion to his wheelchair it was revealed that the resident does not use it</p>	F 280	<p>A.) Residents R65, R5, and R98 had the potential to be impacted. Transfer and preferences updated on care plan for R65, Previous order removed from R5's care plan, and Preadmission Screening and Resident Review - Level 2 (PASRR-II) notes added to care plan for R98.</p> <p>B.) All Residents have the potential to be affected. A whole house audit will be conducted for the following: 1.) all PASSR-II recommended interventions and care planned in accordance to PASRR-II recommendations. 2.) all Resident safety interventions will be reviewed along with identified Resident preferences to assure the appropriate care plan.</p> <p>C.) MDS Coordinators, Social Workers, and Nursing will meet weekly to review care plans to reported weekly activity to</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	<p>Continued From page 15 because it does not work.</p> <p>Observation on 1/24/17 at 11:00 AM revealed R65 did not have a Dycem in his wheelchair.</p> <p>An interview on 1/24/17 at 11:15 AM with E14 (CNA) revealed that R65 does not use the Dycem in his wheelchair because he does not like it.</p> <p>During an interview on 1/25/17 at 12:12 PM with E10 (RN, UM) about the orange sheet in the CNA book about not being left unattended in the bathroom it was revealed that for the privacy of the resident, staff are to stand outside the bathroom door in case the resident needs help. E10 stated that the orange sheet had been removed from the CNA book. This approach was not included in the care plan. There was no further information on the inconsistencies with the Dycem use and the approach in the care plan that it was being used.</p> <p>2. Review of R5's clinical record revealed; R5's care plan dated 10/9/15 and last reviewed 1/5/17 included a care plan for alteration in hydration/fluid volume with approaches that included "fluid restriction as ordered".</p> <p>Review of the record lacked evidence that a fluid restriction was ordered or being implemented.</p> <p>During an interview on 1/26/17 at 10:42 AM with E10 it was revealed that R5 was no longer on a fluid restriction. In a follow-up interview shortly thereafter E10 told the surveyor that the approach was on the care plan in case a fluid restriction was ordered.</p> <p>3. Review of R98's clinical record revealed;</p>	F 280	<p>assure updates and corrects occurred.</p> <p>D.) Social Services Director and DON and/or designee will review all new PASRR-II to assure compliance with recommendation to care plan. Safety Interventions for five (5) Residents will be audited for appropriateness and in coordination with Resident preferences for four (4) weeks until 100% compliance is reached for four (4) consecutive weeks. Then, monitor / audit monthly until consistently reaching 100% success for three (3) monthly evaluations. If 100% compliance is reached after the end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained. Evaluation success will be reviewed at Quarterly Quality Assurance meeting.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page 16 5/25/15 - Care plan for depression included interventions to provide emotional support as needed and psychiatric consult as needed. 12/16/16 - R98's PASRR II documented specialized services and recommendations to include weekly psychotherapy to address all of his ongoing issues. The therapy is to be provided by a licensed mental health provider. Resident also to have a monthly assessment and medication management by a psychiatric NP or psychiatrist. The resident's care plan was not revised to include PASRR II recommended specialized services. During an interview with E12 (RN, UM) on 1/24/17 at 3:35 PM E12 confirmed R98's care plan was not revised to include the details of the PASRR II recommendations.	F 280			
F 315 SS=D	These findings were reviewed with E1 (NHA) and E2 (DON) on 1/26/17 at 3:20 PM. 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the	F 315			3/31/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 315	<p>Continued From page 17 facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide the care and services to prevent infection for one resident [R209] out of 38 sampled residents, with an indwelling urinary catheter. Findings include:</p> <p>Infection control facility policy (last revised June 2014) entitled Guidelines for Preventing Urinary Tract Infections (Catheter- Associated) included the procedure to keep the drainage bag below the level of the bladder at all times.</p>	F 315	<p>A.) Facility cannot provide retroactive compliance to Resident 209.</p> <p>B.) All Residents with a catheter have the potential to be affected.</p> <p>C.) Education will be provided to all clinical staff by the Staff Developer on catheter equipment placement during care. Education will be added annually and on new hire orientation to all nursing staff.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 315	Continued From page 18 Review of R209's clinical record revealed: 12/29/16 - R209 was readmitted from the hospital with an indwelling urinary catheter after treatment for pneumonia. 1/25/17 - Observation of R209's repositioning in bed by E18 (CNA) and E19 (CNA) after dressing change by E20 (RN) discovered clear yellow urine in the indwelling urinary catheter drainage tubing. When moving the urinary drainage bag from one side of the bed to the other E18 held the catheter drainage bag around 12 inches above the resident in bed and held it there for at least 5 seconds waiting for E19 to take it. E19 placed it on the other side of the bed frame below the level of R209's bladder. When the drainage bag is above the level of the bladder, urine in the tubing can flow back into the bladder increasing the chance of infection. 1/25/17 at 11:40 AM - Surveyor reviewed the observed positioning of the urinary drainage bag above the resident's bladder with E18 and E20 and both confirmed the incorrect positioning of the bag above the resident's bladder. During an interview with E19 on 1/2/5/17 at 11:45 AM E19 said she thought E18 was going to "put it on the bed and I would move it from there." This finding was reviewed with E1 (NHA) and E2 (DON) on 1/26/17 at 3:20 PM.	F 315	D.) Unit Managers / designee will coordinate to review three (3) observations of catheter equipment placement during care, weekly, for four (4) weeks until 100% compliance is reached for four (4) consecutive weeks. Then, monitor / audit monthly until consistently reaching 100% success for three (3) monthly evaluations. If 100% compliance is reached after the end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained. Evaluation success will be reviewed at Quarterly Quality Assurance meeting.		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents.	F 323			3/31/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	<p>Continued From page 19</p> <p>The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R65) out of 38 sampled residents the facility failed to provide adequate supervision to prevent accidents. The facility failed to ensure that R65, who had several falls, and was a two person transfer, was consistently assisted in the bathroom by two staff members. Findings include:</p> <p>The following was reviewed in R65's clinical record:</p>	F 323	<p>A.) Resident R65 was potentially impacted. Resident R65's care plan was immediately updated to show preference; and corresponding documentation was audited and corrected where necessary</p> <p>B.) All Residents with two (2) person assist transfer status could be affected. A whole house audit will be conducted for safety equipment to match care plan and preferences, cross-refer to audit for F-280.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	<p>Continued From page 20</p> <p>9/2/15 reviewed 1/5/17 - Care plan for resident has the potential for falls related to lower extremity weakness and morbid obesity (list of numerous falls including 8/8/16, 9/17/16, 9/19/16, 10/22/16, 10/29/16, 11/15/16, 12/22/16, 12/27/16, 1/22/17) with approaches that included:</p> <ul style="list-style-type: none"> -resident is a two person transfer -resident is to have two staff members present when showering -provide resident with a reacher to assist with picking items up off the floor...encourage resident to ask for assistance and engage brakes when wheelchair is stationary -grab bar beside bed to enable resident to assist with transfers -verbal reminders -call light in reach at all times -keep personal items and frequently used items within reach -non-slip footwear -safety devices as ordered: non-skid footwear, dycem above and below w/c cushion, toileting plan. 9/19 low bed and landing strips x1, 10/4 landing strip d/c due to refusal and his request to d/c, 1/23 anti rollbacks on w/c <p>1/27/16 reviewed 1/5/17 - Care plan for (resident name) safety hazard to self as evidenced by transferring without assistance approaches included:</p> <ul style="list-style-type: none"> -encourage to call for assistance -assess for pain, toileting needs, comfort -document episodes of behavior -educate resident regarding need for assisted transfers and possible negative outcomes of non-compliance -give frequent safety reminders <p>4/18/16 - Functional Mobility/Transfer Status form</p>	F 323	<p>C.) Staff Developer will provide education to all staff as to whereto locate transfer status; and how to handle transfer status during a fall. Transfer status will be added to electronic plan of care notifications for quick access to all care takers.</p> <p>D.) Director of Nursing / Designee will review safety interventions and transfer status during interdisciplinary meetings during fall review and after any new fall, weekly, for four (4) weeks until 100% compliance is reached for four (4) consecutive weeks. Then, monitor / audit monthly until consistently reaching 100% success for three (3) monthly evaluations. If 100% compliance is reached after the end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained. Evaluation success will be reviewed at Quarterly Quality Assurance meeting.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	<p>Continued From page 21</p> <p>in CNA book documented R65 needed two persons with transfers.</p> <p>8/8/16 - Incident report of fall in bathroom occurred when resident attempted to transfer self.</p> <p>8/22/16 - Annual MDS documented the resident was cognitively intact, required extensive assistance with two person support for transfers and toileting and had two or more falls with no injury since the last assessment.</p> <p>9/17/16 - Incident report stated that resident fell twice. Once trying to self transfer to the toilet and once out of bed trying to use the urinal.</p> <p>10/22, 10/29, and 11/15/16 - Incident reports for resident falls attempting to self transfer to the toilet.</p> <p>12/22/16 - Incident report for resident fall in dining room while napping in w/c.</p> <p>12/27/16 - Incident report for fall in bathroom while being assisted by only one aide. Review of the incident report and additional documentation provided by the facility failed to identify that the resident was a two person transfer and only one staff member was assisting the resident in the bathroom. There were no injuries noted.</p> <p>1/22/17 - Incident report for fall from wheelchair while trying to transfer self to bed.</p> <p>1/24/17 - Review of the CNA book on the unit revealed a bright orange laminated sheet that documented (NAME OF RESIDENT) IS NOT TO BE LEFT UNATTENDED IN THE BATHROOM.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 22</p> <p>1/24/17 10:31 AM - Resident in bathroom with door closed no other voices identified when surveyor knocked on bathroom door, no staff in room or in hall near resident's room. No reacher was seen in the room.</p> <p>During an interview with R65 on 1/24/17 at 10:47 AM it was revealed that two aides transferred him to the toilet and he was alone in the bathroom until two aides came and transferred him back to his wheelchair. When asked where his reacher was he said behind the bed. When surveyor looked behind the bed it could not be found. When asked about the no slip Dycem cushion to his wheelchair he stated that he does not use it because it does not work. The resident later told surveyor that the reacher was found behind the bed.</p> <p>1/24/17 11:00 AM - Observed staff transfer resident to bed so anti-rollbacks could be added to his wheelchair. There was no Dycem in the w/c.</p> <p>An interview on 1/24/17 at 11:15 AM with E14 (CNA) revealed that R65 is a two person transfer and is able to be left alone in the bathroom for privacy. It was also revealed that he can use a urinal with one person assist. E14 stated that the resident does not use the Dycem in his wheelchair because he does not like it.</p> <p>During an interview on 1/24/17 at 11:56 AM with E10 (RN, unit manager) revealed that after reviewing the 12/27/16 incident report it looked like only one aide was transferring R65.</p> <p>During an interview on 1/25/17 at 12:12 PM with E10 about the orange sheet in the CNA book</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 23 about not being left unattended in the bathroom it was revealed that for the privacy of the resident staff are to stand outside the bathroom door in case the resident needs help. E10 stated that the orange sheet had been removed from the CNA book. There was also no further information concerning the 12/27/16 fall in relation to why only one aide was transferring the resident. On 12/27/16 R65 had a fall in the bathroom while only one staff person was assisting with a transfer. The facility failed to identify this failure in their review of the incident. The facility was also found to be inconsistent in their use of assistive devices (Dycem) and supervision with resident toileting. These findings were reviewed with E1 (NHA) and E2 (DON) on 1/26/17 at 3:20 PM.	F 323			
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 334			3/31/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 334	<p>Continued From page 24</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p>	F 334			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 334	<p>Continued From page 25</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that one (R195) out of 5 sampled residents received their flu shot. Finding include:</p> <p>R195's records indicated the resident was cognitively impaired for decision making.</p> <p>An Immunization Consent Annual Flu Vaccine form dated 8/3/16 documented that R195's responsible party gave verbal consent for the administration of the flu vaccine.</p> <p>On 9/29/16 a physician's order was documented in the EMR for the one time dose of flu vaccine. On the same date it was documented in the comment section for medication administration history that the vaccine was not administered because the resident refused.</p> <p>Review of progress notes lacked evidence of attempts to administer the vaccine.</p> <p>During an interview on 1/26/17 around 10:00 AM with E11 (RN staff education and infection control) it was revealed that there was no evidence that the resident was offered the flu vaccine more than once. He/she went on to add</p>	F 334	<p>A.) Resident R195 was reoffered and R195's response was shared with Responsible party. Consent modified to R195's request.</p> <p>B.) All Residents with power of attorney (POA) consents with Resident refusals could be affected. A whole house audit will be conducted to verify if any other Residents have similar refusals to consents.</p> <p>C.) Staff Developer will educate nursing staff on reporting refusals of immunizations. All immunization refusals will be reported to the Director of Nursing or the Assistant Director of Nursing for review, audit to consent, education, and confirm changes.</p> <p>D.) Director of Nursing and Assistant Director of Nursing will review all new refusals weekly, for four (4) weeks until 100% compliance is reached for four (4) consecutive weeks. Then, monitor / audit monthly until consistently reaching 100% success for three (3) monthly evaluations. If 100% compliance is reached after the</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 334	Continued From page 26 that it would be expected that three attempts would be made to administer the vaccine and progress notes should be written about the refusals. It was confirmed that there was no evidence of this. During an interview on 1/26/17 at 11:19 AM with E12 (RN, UM) about R195's flu vaccine it was confirmed that three attempts should be made to administer the vaccine. E12 could find no further information that the vaccine administration was attempted after the first refusal. These findings were reviewed with E1 (NHA) and E2 (DON) on 1/26/17 at 3:20 PM.	F 334	end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained. Evaluation success will be reviewed at Quarterly Quality Assurance meeting.		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		3/31/17	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	<p>Continued From page 27</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	<p>Continued From page 28</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to process linens in a manner that prevented the spread of infection. Findings include:</p> <p>In order to prevent the transmission of airborne infectious organisms, laundry rooms used for sorting and washing soiled linen must be under negative air pressure, laundry rooms used for drying and folding clean linen must be under positive air pressure, and all doors must remain closed.</p> <p>On 1/26/17 the following was observed during a tour of the laundry area:</p> <ul style="list-style-type: none"> - Around 10:00 AM during an observation of the laundry rooms E15 (housekeeping supervisor) was approached about testing the positive and negative air pressures in the soiled and clean laundry rooms. E15 directed the surveyor to the maintenance director (E5) who he/she stated would be responsible for that. - Around 11:00 AM E5 was asked about the pressure testing and stated he/she would meet with the surveyor. - 11:30 AM the surveyor went to the laundry area to meet with E1 (NHA), E5 and E15 who were unsure how to test the air pressures in each room. The surveyor provided a tissue and instruction to check for air pressure in each room. 	F 441	<p>A.) Facility contractor for ventilation called immediately; and verified that room had negative pressure through the functioning fan unit.</p> <p>B.) All residents could be directly impacted.</p> <p>C.) Fan unit will be direct wired to circuit breaker with breaker locations labeled for lock-out / tag-out for servicing. Circuit breaker will be added to generator panel to assure usage during a power outage. This individual unit will have its own separate monthly preventative maintenance schedule.</p> <p>D.) Maintenance Director will inspect the unit weekly and observe laundry staff's awareness of the unit's operation, for four (4) weeks until 100% compliance is reached for four (4) consecutive weeks. Then, monitor / audit preventative maintenance program monthly until consistently reaching 100% success for three (3) monthly evaluations. If 100% compliance is reached after the end of three (3) evaluation periods, facility will conclude that compliance has been obtained and maintained. Evaluation success will be reviewed at Quarterly Quality Assurance meeting.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2017
NAME OF PROVIDER OR SUPPLIER HARBOR HEALTHCARE & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 OCEAN VIEW BLVD LEWES, DE 19958		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	<p>Continued From page 29</p> <p>Negative air pressure could not be established in the dirty laundry room and positive air pressure could not be established in the clean laundry room. E1 and E5 stated that they would have it assessed and fixed.</p> <p>A follow-up phone call from E1 on 1/27/17 around 9:00 AM revealed that a contractor visited the facility last evening and was able to get the pressures working. E1 stated that a control had been turned off and cleaning needing to be done.</p> <p>The facility failed to maintain the receiving area for contaminated linens under negative air pressure compared with the clean areas of the laundry in order to prevent or minimize the transmission of airborne infectious organisms.</p>	F 441			



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 1 of 1

NAME OF FACILITY: Harbor Health Care

DATE SURVEY COMPLETED: January 26, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	<p>The State Report incorporates by references and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey was conducted at this facility from January 19, 2017 through January 26, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 142 (one hundred forty two). The survey sample totaled 38 (thirty eight).</p>		
3201.1.0	<p>Regulations for Skilled and Intermediate Care Facilities</p>	<p>Cross refer to CMS 2567-L, received on February 8, 2017.</p>	3-31-2017
3201.1.2	<p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of the Regulation, as fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by: Cross refer to CMS 2567-L survey completed January 26, 2017: F164, F246, F253, F272, F279, F280, F315, F323, F334, and F441</p>	<p>Related Plan of Correction for the above addresses: F164, F246, F253, F272, F279, F280, F315, F323, F334, and F441</p> <p>This plan of correction received on February 8, 2016, constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by State and Federal law.</p>	

Provider's Signature

Title

Administrator

Date

2/17/2017